MOUNTAIN LAKE ACADEMY
386 River Road Lake Placid, NY 12946
phone: (518) 523-4300 fax: (518) 523-5322

ADMISSION REQUIREMENTS and NOTICES

Once placement at Mountain Lake Academy is confirmed, the Admissions Office will work with both the referring school/agency and the parent(s)/guardian(s) to prepare for admission.

Please contact our Admissions Counselors with questions at 518-523-4300 or admissions@mountainlakeacademy.org.

The following items must be received *prior to admission*:

Referring School/Agency:

1) **School records from the last two (2) years, including:** current transcript; current report card; IEP; behavior summary; and educational testing materials (if applicable)
2) **Mental health assessments, including:** evaluations, testing, discharge summaries from any placements or hospitalizations
3) **Court documents, including:** court orders; probation reports; and any court documents not previously received

   School placements only:
   - STAC submission and approval
   - Schedule CSE meeting with Mountain Lake Academy to update IEP

   DSS placements only:
   - Connections, including:
     i. Most recent FASP or Plan Amendment
     ii. Assign to Mountain Lake Academy Security Administrator (Victoria Savard)
     iii. Reflects appropriate "Program Choice"
     iv. Designate health access to Mountain Lake Academy

Parent(s)/Guardian(s):

1) **Completed application**
2) **Consent forms** (please fax or email when complete; originals must accompany the student at the time of admission)
3) **Copies of the following:**
   - Private medical, dental, and/or optical insurance cards (both sides), including identification and contact information (insurance will be billed for medical services as well as St. Joseph's outpatient substance abuse treatment)
   - Medicaid card (if applicable)
   - Birth Certificate
   - Social Security Card
4) **Medication**, 15-day supply
5) **Prescription order** from prescribing physician
6) **Most recent physical exam**, including **immunization record**

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ADDITIONAL INFORMATION

- **Clothing** will be issued to the student by Mountain Lake Academy upon admission, including:
  - khaki pants and polo shirts (school apparel)
  - undergarments (underwear, undershirts, socks), pajamas, and a belt
  - jeans and t-shirts (weekend/evening apparel)
  - seasonal outerwear (hat, gloves, coat, boots, hiking boots)
  - gym shoes/sneakers (upon admission, students are allowed one (1) pair of sneakers from home that are neutral in color, clean, free of markings, and in good condition)

- **Personal hygiene items** will be supplied upon admission.
  - Please advise the Nursing Department if your student has a skin sensitivity or requires prescribed products (please provide the prescription upon intake).

- **Students are not permitted to carry cash on campus.**
  - An in-house account will be maintained in your student's name for work study hours worked, to be paid out after discharge from Mountain Lake Academy.

- **Please ensure that your student is not carrying unauthorized materials** upon intake at Mountain Lake Academy. Materials not allowed on campus include but are not limited to:
    - Lighters
    - Tobacco/nicotine products (vapes, cigarettes, chewing tobacco)
    - Personal food items
    - Personal accessories (jewelry, bandanas, clothing items)
    - Money
    - Electronic devices (cellular phones, handheld games, mp3 players)
    - Prescription medication

- **Consent forms** are available from Family Support Specialists for students who wish to request certain personal items (mp3 players, religious or sentimental items, etc.). Personal items that arrive on campus without prior approval will be confiscated. Mountain Lake Academy assumes no responsibility for students' personal belongings.

- **Student wellness** is emphasized at Mountain Lake Academy by promoting students' health, well-being, a healthy diet and physical activity. The Wellness Policy is detailed in the Parent Handbook. Please notify your student's Family Support Specialist with any feedback for our food service personnel or if you wish to participate in a committee addressing student wellness.

- **NYS Department of Health** requires Mountain Lake Academy to calculate the Body Mass Index (BMI) of all students as part of their school health examination. Please alert your Family Support Specialist if you wish to opt-out of this anonymous report on your student's behalf.

- **Photography or video** may be taken during your student's enrollment at Mountain Lake Academy. Your Family Support Specialist will notify you if photographs or video will be used publicly. Please notify your Family Support Specialist if you wish to revoke consent at any time.
  - **Note: One (1) photograph will be taken of the student upon admission for identification use.**

Please contact our Admissions Counselors with questions at 518-523-4300 or admissions@mountainlakeacademy.org.

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Admission Information

Name: _____ Address: _____

DOB: _____ Height: _____ Weight: _____ Eye color: _____ Hair color: _____ Race: _____

Religious affiliation: _____ Language spoken: _____ Identifying marks: _____

Date of referral: _____ Placement expiration date:_____ Court-adjudicated status: ☐ JD ☐ PINS ☐ Article 10 ☐ n/a

Shoe size: _____ Pant size: _____W x _____L Shirt size: _____ Shorts size: _____ Preference: ☐ boxers ☐ boxer-briefs

Favorite meal: _____

Education Information

Current School District: _____

Address: _____ Phone: _____ Fax: _____

CSE Chair: _____Tel: _____ Email: _____

IEP Classification: _____ Grade: _____

Parent/Guardian Information

Parent/Guardian: _____ Parent/Guardian: _____

Address: _____ Address: _____

Phone: _____Cell: _____ Phone: _____ Cell: _____

Email: _____ Email: _____

Occupation: _____ Occupation: _____

Parent Marital History

☐ Child's biological parents were never married ☐ Separated – Date: _____

☐ Married to each other – Date: _____ ☐ Divorced – Date: _____

Parental Custodian(s): _____

Legal relationship between child and parent (i.e. biological, adopted, guardian): _____

Any special circumstances regarding parental rights (i.e., visitation): _____

Primary Family

Father _____ Age _____ DOB _____ Residence_____

Mother _____ Age _____ DOB _____ Residence _____

Step-father _____ Age _____ DOB _____ Residence_____

Step-mother _____ Age _____ DOB _____ Residence_____

Sibling(s) _____ Age _____ DOB _____ Residence_____

Sibling(s) _____ Age _____ DOB _____ Residence_____

Sibling(s) _____ Age _____ DOB _____ Residence_____

Sibling(s) _____ Age _____ DOB _____ Residence_____

List anyone other than primary family living in your child's home:

_____

List anyone other than parents who routinely provide care or supervision for your child:

_____

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Child's Residential History

Chronological timeline of your child's residential / day placements, hospitalizations, and school settings (including dates): _____

_____

_____

_____

Describe your present home and neighborhood: _____

Past and Pending Legal Involvement

Has your child been charged or convicted of any crime? ☐ Yes ☐ No

Does your child have any pending charges or any upcoming court dates? ☐ Yes ☐ No

If "Yes," please specify any violations / charges / convictions: _____

_____

_____

_____

If "Yes," please provide any issued probation or court orders with this admissions packet.

I attest that this information regarding my child's legal involvement is true, accurate, and complete and understand that any falsification, omission, or concealment of material fact may jeopardize my child's placement at Mountain Lake Academy.

_____ _____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian Date

Legal/County Information (if applicable)

County Caseworker: _____
Address: _____
Phone: _____Fax: _____
Email: _____
Emergency contact phone: _____

Probation Officer: _____
Address: _____
Phone: _____Fax: _____
Email: _____
Emergency contact phone: _____

Insurance Information

Insurance Company: _____ Policy number: _____

Employer: _____ Contract holder: _____ Contract holder DOB: _____

Plan Type: _____ Coverage: ☐ Medical ☐ Dental ☐ Optical ☐ Prescription

Medicaid # (first set of letters and numbers at top of card): _____

Sequence # (last two numbers at bottom of card): _____ State: _____ SSI/SSA Disability: ☐yes ☐ no If yes, Payee: _____

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Medical History

List all known allergies: _____

Medical alerts and directives (i.e., asthma, etc.): _____

Infectious Diseases

- ☐ Chicken pox
- ☐ Cholera
- ☐ Chronic bladder infection
- ☐ Chronic bronchitis
- ☐ Chronic ear infections
- ☐ Chronic sinus infections
- ☐ Chronic tonsillitis
- ☐ Diphtheria
- ☐ HIV/ AIDS
- ☐ Malaria
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Novel coronavirus (COVID-19)
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Rubella
- ☐ Scarlet fever
- ☐ Sinusitis
- ☐ Small pox
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Whooping cough

Major Medical Problems or Illnesses

- ☐ Anemia
- ☐ Asthma
- ☐ Broken bones
- _____
- ☐ Chronic fatigue syndrome
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy or seizures
- ☐ Head injury/knocked out
- ☐ Hearing problems
- ☐ Heart defect or disease
- ☐ Hemophilia
- ☐ Intestinal disease
- ☐ Kidney disease
- ☐ Lead poisoning
- ☐ Liver disease
- ☐ Lung disease
- ☐ Muscle spasms or tics
- ☐ Stomach disease
- ☐ Thyroid disease
- ☐ Other _____

Immunization History

- ☐ Diphtheria/Tetanus/Pertussis
- ☐ Chicken pox
- ☐ Measles/Mumps/Rubella
- ☐ Pneumococcal pneumonia
- ☐ Haemophilus influenzae
- ☐ Other influenza
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Polio
- ☐ COVID-19

Mental health diagnoses, behavioral health diagnoses, and any surgeries (age and description): _____

_____

Medication	Dosage	Reason Taken

Primary Care Physician (phone): _____ Dentist/Orthodontist (phone): _____

Prescribing Physician / Psychiatrist (phone): _____ Date of last dental exam: _____

Date of last medical exam: _____ Does child wear: ☐ Orthodontic Braces ☐ Eyeglasses ☐ Hearing Aid ☐ Prostheses

List any major medical problems in the family history: _____

_____

Recent Physical Concerns

- ☐ Sleep problems
- ☐ Frequent complaints of physical problems
- ☐ Unexplained fevers, chills, hot flashes, sweating
- ☐ Dizzy, unsteady, lightheaded, or faint
- ☐ Excessive energy, tiredness or fatigue
- ☐ Weight loss or very low weight
- ☐ Weight gain or obesity
- ☐ Headaches
- ☐ Double vision or blindness
- ☐ Deafness or ringing in the ears
- ☐ Numbness or tingling
- ☐ Trembling or shaking
- ☐ Muscle or joint pain
- ☐ Muscle spasms or tics
- ☐ Clumsiness
- ☐ Paralysis or localized weakness
- ☐ Difficulty swallowing or choking
- ☐ Chest pain
- ☐ Palpitations, pounding or rapid heartbeat
- ☐ Shortness of breath or smothering
- ☐ Abdominal pain
- ☐ Appetite increase or decrease
- ☐ Nausea or vomiting
- ☐ Diarrhea or constipation
- ☐ Urinary problems
- ☐ Sexual problems

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SOCIAL SECURITY NUMBER

To ensure the student's privacy, this is the only location where we ask for the student's Social Security Number to be recorded.

_____ _____/_____/_____
Student's Name (please print) Social Security Number

Copy of Social Security Card in box

CONSENT FOR ROUTINE MEDICAL AND DENTAL CARE

STUDENT'S NAME: _____ DOB: _____

I, _____, hereby give my consent for routine medical and dental care to the above-listed person. I also understand my insurance plan will be billed; however, I am responsible for any uncovered expense. Routine care may include, but is not limited to: physical examination; immunization against communicable disease; administration of over-the-counter medications (listed below); treatments in accordance with the agency's policies, procedures, and practices; and any diagnostic tests or treatment which, in the opinion of the consulting physician or dentist, are deemed necessary or advisable. I understand that I will be informed of any medical incidents requiring special or unusual medical or dental care.

Over-the-Counter Medications

1. Tylenol (acetaminophen): 325 mg, 2 tabs by mouth every 4 hours as needed for complaint of pain.
2. Motrin (ibuprofen): 200 mg, 2 tabs by mouth every 4 hours as needed for complaint of pain.
3. Bengay or Icy Hot (muscle rub): topical application as needed for complaint of muscle pain.
4. Benzocaine lozenges: 1 lozenge every 2 hours as needed for complaint of sore throat or cough.
5. Pseudoephedrine HCL 30 mg: 1-2 tabs by mouth as needed for nasal congestion.
6. Maalox (or generic equivalent) liquid: 15 cc by mouth every 4 hours as needed for complaint of upset stomach/diarrhea.
7. Tums Antacid 750 mg: 2 tabs by mouth every 4 hours for upset stomach, acid indigestion.
8. Omeprazole 20 mg: 1 tab by mouth every morning, 20 minutes before breakfast for acid reflux.
9. Milk of magnesia 60cc: every 6hr as needed for constipation. Take with 8 oz. glass of water.
10. Colace or docusate sodium 100 mg: 1-2 caps by mouth every 12 hours as needed for constipation.
11. Miralax or polyethylene glycol 3350 NF 17g: in 8oz of water as needed for constipation.
12. Guaifenesin: as per manufacturer's dosages as needed for complaint cough/congestion.
13. Chloraseptic spray (or generic equivalent): 2-4 sprays to throat every 2 hours as needed for complaint of sore throat.
14. Multiple vitamin: 1 by mouth every morning as needed.
15. Burn Jel with lidocaine HCL 2%: three or four times a day as needed for complaint of burns.
16. Povidone/iodine swabs: topical application to minor skin breaks.
17. Hydrogen peroxide: As directed.

18. Calamine lotion, Vitamin A&D ointment or zinc oxide cream: topical application to minor skin irritation.
19. Triple Antibiotic Ointment: topical application to minor skin breaks or as directed.
20. Blistex (or brand name/generic equivalent): topical application to dry or blistered cold sores on lips.
21. Benadryl: 25 mg, 1-2 tabs by mouth at bedtime as needed for insomnia.
22. Benadryl: 25 mg, 1-2 tabs by mouth every 4 hours for allergic reactions.
23. Benzoyl peroxide and salicylic acid 2%: topical application for acne as directed.
24. EPIPEN (Epinephrine auto injector): as needed for severe allergic reactions.
25. Claritin or loratadine: (1) tab daily as needed for allergy symptoms.
26. Zyrtec or cetirizine HCL 10mg: 1 tab daily as needed for allergy symptoms.
27. Melatonin 3 mgs: 1-2 tabs by mouth at bedtime as needed for insomnia.
28. Dimenhydrinate HCL: 50 mg 1-2 tabs every 6-8 hours for motion sickness.
29. Sunscreen: SPF no less than 15 (generic).
30. Bug spray: with 5–10% Deet (generic).
31. Preparation H, Anusal, or hemorrhoid pads (generic): as needed for complaint of hemorrhoids.
32. Band-Aid Foaming Cleanser & Antiseptic: cleansing and infection protection.
33. Tinactin antifungal foot medication: as needed for signs and symptoms of athlete's foot.
34. Abreva Cold Sore Treatment: Topical application to dry or blistered cold sores on lips.
35. Orajel Mouth Sore Medication: apply topically.
36. Hydrocortisone cream for itching and minor hive reaction.
37. Saline nasal or decongestant spray for sinus congestion.
38. Lubricating eye drops: use as directed on bottle.
39. Aloe vera gel for sunburns or minor skin irritation and breaks.
40. Vicks VapoRub: apply topically, cough suppressant and topical analgesic.
41. Immodium AD: 2 teaspoons after each loose stool (max 4 teaspoons/day).
42. Permethrin: 280 mg (1%), once a week for 2 weeks for treatment of head lice.

_____ _____

Signature (Parent/Legal Guardian) Date

_____ _____

Print Name (Parent/Legal Guardian) Relationship to Student

EMERGENCY MEDICAL CARE/SURGERY

I, _____, parent/legal guardian of

_____, DOB: _____, do hereby

authorize the Executive Director of Mountain Lake Academy to act on my

behalf in the event of any urgent medical treatment including physical as well as emotional

needs, which may be required. I also guarantee to pay for any expenses incurred during this process.

I understand that it is the obligation of Mountain Lake Academy, to make every effort to contact me

prior to the beginning of any process, or as soon as I can be reached.

_____ _____

Signature (Parent/Legal Guardian) Date

_____

Print Name (Parent/Legal Guardian)

STUDENT AND FAMILY RESPONSIBILITIES

- **Read and understand the Student Code of Conduct.** A copy of the Mountain Lake Academy Student Code of Conduct will be provided to the student and to the parent(s)/guardian(s) upon admission. It is your responsibility to familiarize yourself with the Student Code of Conduct and to ask questions about anything therein that you do not understand. It is the parent's/guardian's responsibility to ask questions about anything in the Student Code of Conduct that s/he does not understand.
    - **Know your rights.** The Student Code of Conduct lists the rights of every Mountain Lake Academy student, including the right to free education and the right to learn in a safe, supportive, and orderly environment. It is your responsibility to know and understand your rights and to ask questions about any of these rights that you do not understand.
    - **Accept your responsibilities.** The Student Code of Conduct lists the responsibilities of every Mountain Lake Academy student, including the responsibility to contribute to maintaining a safe and orderly school environment that is conducive to learning, and to show respect for other persons and property. It is your responsibility to know and accept your responsibilities and to ask questions about any of these responsibilities that you do not understand.

- **Communicate with your Family Support Specialist.** The Family Support Specialist is the point person for the student and for the parent(s)/guardian(s). It is your responsibility to provide accurate and complete information about history of treatment, care, and services to the Family Support Specialist. It is your responsibility to communicate about service needs, expectations, and the quality of Therapeutic Family Visits (TFV). It is your responsibility to communicate any unexpected changes in the student's condition and home situation that may affect student conduct or performance. Recognize that the education and treatment of your student is the joint responsibility of the parent(s)/guardian(s) and the Mountain Lake Academy community. It is your responsibility to maintain a positive, supportive attitude toward education and Mountain Lake Academy and to build good relationships with staff.

- **Comply with treatment recommendations.** You are responsible for following the care, service, or treatment plan that you develop with your student, your parent(s)/guardian(s), and your Family Support Specialist. It is your responsibility to express any concerns about your ability to follow and comply with the proposed care plan or course of treatment. Mountain Lake Academy staff will make every effort to adapt the plan to the student's specific needs and strengths. It is your responsibility to ask questions when you do not understand what you have been told about your student's care or what the expectations are for you or your student. It is the student's responsibility to ask questions when he does not understand what he has been told about his own care or what is expected of him related to that care.

- **Respect Mountain Lake Academy rules and regulations.** It is your responsibility to conduct yourself in an appropriate and civil manner with proper regard for the rights and welfare of students, staff, and visitors, and for the care of school facilities and equipment. Respect for law and for persons in authority is expected of all students. Respect for the rights of others, real and personal property, pride in one's work, achievement within the range of one's ability, and exemplary personal standards of courtesy, decency, politeness, and honesty will be maintained. **As the legal guardian, I understand and consent to the use of Therapeutic Crisis Intervention (Cornell TCI) curriculum, including physical interventions, should my child become an imminent risk to self or others.**

- **Smoking is not permitted** at Mountain Lake Academy. It is the responsibility of the student and the parent(s)/guardian(s) to refrain from smoking on campus.

- **Unauthorized materials are not permitted on campus.** Following Therapeutic Family Visits (TFVs), whether they take place in your home or in the Lake Placid community, please ensure that your student is not carrying unauthorized materials upon return to Mountain Lake Academy. Materials not allowed on campus include but are not limited to:
    - Lighters
    - Tobacco/nicotine products (vapes, cigarettes, chewing tobacco)
    - Personal food items
    - Personal accessories (jewelry, bandanas, clothing items)
    - Money
    - Electronic devices (cellular phones, handheld games, mp3 players)
    - Prescription medication (all prescribed medication taken over the course of a TFV should be noted on the Off Campus Medication Dispensation form provided by your student's Family Support Specialist; for more information, please contact the Nursing Department at 518-523-4300, ext. 120)

- **Obtain consent for student belongings.** It is your responsibility to follow proper procedure to obtain consent to bring personal items on campus. Consent forms are available from your Family Support Specialist if your student wishes to request certain personal items (mp3 players, religious or sentimental items, etc.). Personal items that arrive on campus without prior approval will be confiscated. Mountain Lake Academy assumes no responsibility for students' personal belongings. Mountain Lake Academy strongly recommends that valuables remain at home. At no time will restitution be made for loss or damage to personal property. In some instances, Mountain Lake Academy may forbid certain items if it appears that the student is unable to properly secure them.

- **Accept the consequences.** It is the responsibility of the student and the parent(s)/guardian(s) to follow the care, service, and treatment plan for their student. It is the responsibility of the student and parent(s)/guardian(s) to follow all Mountain Lake Academy rules and regulations. You assume responsibility for any outcomes/consequences of not following the care, service, and treatment plan and/or Mountain Lake Academy rules and regulations.

- **Photography or video** may be taken during your student's enrollment at Mountain Lake Academy. Your Family Support Specialist will notify you if photographs or video will be used publicly. Please notify your Family Support Specialist if you wish to revoke consent at any time. A form is included in this packet (page 15) to allow or deny consent to photography or video.
    - **Note: One (1) photograph will be taken of the student upon admission for identification use.**

I have received a copy of the Mountain Lake Academy Student Code of Conduct. I have read and understand the attached information regarding student and parent/guardian expectations of Mountain Lake Academy. Any questions I had regarding this information were asked and answered.

Student Signature	**Date**
Parent/Guardian Signature	**Date**

MOUNTAIN LAKE ACADEMY
386 River Road
Lake Placid, NY 12946
Ph: 518-523-4300
Fax: 518-523-5322

Academic Records Release

School Name: _____

School Address: _____

Student Name: _____ DOB: _____ GRADE: _____

The above-listed student has enrolled in Mountain Lake Academy. In order to meet the student's educational needs to the fullest extent, we ask that you provide the following information:

- Date of enrollment in your school/date of withdrawal from your school
- Transcript of grades and credits (quarter grades, semester grades)
- Specific names of courses: Math, Algebra, Social Studies, etc. and class schedule
- Designation of Regents/Honors courses
- Designation of special program: EMR, Special Education, Modified, etc.
- Standardized test results
- New York State Regents Competency Test scores/Regents results
- IEP, if applicable
- Psychological test results and psychiatric test results
- Health records, immunizations records
- Any significant anecdotal information including behavior reports and other education-related information

Thank you for your efforts and consideration in providing this information as soon as possible.

Sincerely,
Christopher Mariano
Executive Director

PLEASE NOTE: PUBLIC LAW 92-380 REGARDING RELEASE OF SCHOOL RECORDS HAS BEEN MODIFIED BY SB 182, ARTICLE 5, PRIVACY OF PUPIL RECORDS, 10947:

> **"A school district is not authorized to permit access to pupil records to any person without parental consent or under judicial order <u>EXCEPT:</u>**

A. <u>ACCESS SHALL BE PERMITTED TO THE FOLLOWING:</u>
OFFICIALS AND EMPLOYEES OF OTHER PUBLIC SCHOOLS OR SCHOOL SYSTEMS INCLUDING COUNTY, OR STATE CORRECTIONAL FACILITIES WHERE EDUCATIONAL PROGRAMS LEADING TO HIGH SCHOOL GRADUATION ARE PROVIDED. WHERE THE PUPIL INTENDS TO OR IS DIRECTED TO ENROLL, SUBJECT TO THE RIGHTS OF PARENTS IS PROVIDED IN SECTION 10939."

_____ _____
Parent/Guardian Signature **Date**

PARTICIPANT INFORMATION
AND
RELEASE OF LIABILITY

DISCLOSURE

Mountain Lake Academy programs involve a variety of activities that often include warm-ups, games, group initiative problems, low and high challenge course elements and other rigorous physical adventure activities. The level of participation in a Mountain Lake Academy activity is at all times voluntary and up to the individual's choice under the Challenge by Choice philosophy. Yet there is a risk which must be assumed by each participant, that he or she may suffer an emotional or a physical injury or disability.

Policy for participation in all Mountain Lake Academy programs requires that every participant have health/accident insurance coverage. In addition, certain health and medical information must be made known to the facilitator(s) conducting the program.

RELEASE OF LIABILITY

I understand that parts of the Mountain Lake Academy program may be physically and/or emotionally demanding. I affirm that my health is good, and that I am not under a physician's care for any undisclosed condition that bears upon my fitness to participate in the Mountain Lake Academy activities. I understand that the level of participation in the activities is at all times voluntary and is the choice of the individual. Also, I recognize the inherent risk of injury or disability in Mountain Lake Academy activities and understand that each participant must assume the risk of injury that could result from any of the activities. I release Mountain Lake Academy, and its staff members, principals and Board from all liability for any injury to me from my participation in Mountain Lake Academy activities.

_____
Print Student Name

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature Date

CONSENT FOR FUNCTIONAL BEHAVIOR ASSESSMENT

Student: _____ DOE: _____

While a student at Mountain Lake Academy, a Functional Behavioral Assessment (FBA) may be recommended for your student. An FBA is a comprehensive way to examine and modify behavior(s) that may be affecting your student's learning potential in school. The FBA (and the behavioral intervention plan that will result from this process) is designed to decrease negative behaviors that hinder learning in the classroom.

If it is determined that your son's performance and success within the academic program is hindered by his choices and behavior, your signature below indicates that with your permission your son's educational team will proceed with the FBA. The Education Team will contact you in the event that you have any questions or would like to be a part of the process. You will receive a copy of this FBA upon its completion. Your assistance and support in this process will be greatly appreciated.

Executive Director: Chris Mariano
Contact Information: (518) 523-4300

Parent/Guardian Signature: _____

Date: _____

PHOTOGRAPHY/MEDIA RELEASE

Student: _____ DOE: _____

Mountain Lake Academy programs involve outdoor activities in the Adirondack Park wilderness as well as on campus. Photography, video, and other media may be taken on hikes, climbs, ski trips, canoe trips, multi-day wilderness excursions, etc., to commemorate these activities and are shared with the student and the student's parent/guardian. In order to convey the unique wilderness component of our programming, Mountain Lake Academy uses images, video, and other media recorded during these activities in promotional material and publications, including brochures, website, and social media.

Please check one of the following:

☐ I hereby give permission for images of my child, captured during my child's enrollment at Mountain Lake Academy, through video, photo, and digital camera, to be used solely for the purposes of Mountain Lake Academy promotional material and publications, including brochures, website, and social media.

☐ Images of my child captured during my child's enrollment at Mountain Lake Academy *may not* be used for the purposes of Mountain Lake Academy promotional material and publications, including brochures, website, and social media.

Parent/Guardian Signature: _____

Date: _____

MOUNTAIN LAKE ACADEMY
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AUTHORIZATION TO OBTAIN INFORMATION

Student: _____ **DOB:** _____

I authorize Mountain Lake Children's Residence to obtain from:

Person / Agency: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

The specific information to be disclosed is:

- ☐ Diagnosis
- ☐ Dates of Admission/Discharge
- ☐ Psychiatric Assessments
- ☐ Psychological Testing
- ☐ Medical History, Medications, Physical, Lab Work
- ☐ Discharge Summary
- ☐ Verbal / Written Communication for Discharge
- ☐ Progress Notes
- ☐ Other (specify):

This information will be used for the following purpose(s):

- ☐ Evaluation and Continuing Treatment
- ☐ Educational Placement / Educational Concerns
- ☐ Coordinating Care
- ☐ Other (specify): _____

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Coordinator of Clinical Records. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district and any school within the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by the Federal Privacy Rules or by New York State Law.

_____ _____
Signature of Legal Guardian or Student and Student's Date of Birth — Date

_____ _____
If Signed by Legal Guardian, Relationship to Student — Signature of Witness

_____ _____
Signature of Staff Person Releasing Information — Title and Date Released

Revised 11/05/13

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AUTHORIZATION TO OBTAIN INFORMATION

Student: _____ **DOB:** _____

I authorize Mountain Lake Children's Residence to obtain from:

Person / Agency: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

The specific information to be disclosed is:

- ☐ Diagnosis
- ☐ Dates of Admission/Discharge
- ☐ Psychiatric Assessments
- ☐ Psychological Testing
- ☐ Medical History, Medications, Physical, Lab Work
- ☐ Discharge Summary
- ☐ Verbal / Written Communication for Discharge
- ☐ Progress Notes
- ☐ Other (specify):

This information will be used for the following purpose(s):

- ☐ Evaluation and Continuing Treatment
- ☐ Educational Placement / Educational Concerns
- ☐ Coordinating Care
- ☐ Other (specify): _____

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Coordinator of Clinical Records. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district and any school within the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by the Federal Privacy Rules or by New York State Law.

_____ _____
Signature of Legal Guardian or Student and Student's Date of Birth — Date

_____ _____
If Signed by Legal Guardian, Relationship to Student — Signature of Witness

_____ _____
Signature of Staff Person Releasing Information — Title and Date Released

Revised 11/05/13

(Rev. 02/2010)

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS and CONSENT FOR TREATMENT

Responsibilities

1. I will respect the confidentiality of others. I will never talk about anyone else I see here. Who I see and what I hear must stay here.

2. I will abstain from all alcohol and non-prescribed mood altering substances while in treatment. Any use of alcohol and /or any other mood altering substance, either prescribed of non-prescribed, will be reported to my counselor by myself at the next session.

3. I will be on time of all activities. If I am not able to do so, I will notify my counselor. If I am more than 15 minutes late for an individual or group session, I should not expect to receive services.

4. I will behave in a responsible, adult way at all times. Physically or verbally abusive may result in dismissal and/or legal action.

5. I will work to the best of my ability with my counselor to make constructive changes in all identified problem areas of my life and will actively participate in all aspects of evaluation and/or treatment I have agreed to.

6. As part of my recovery process, I understand that I must be financially responsible. I understand that here is a fee for service. I will pay this amount of provide insurance forms. My charge is _____ per session.

7. I will submit to urine testing and or alcosensor when asked in order to determine chemical free state.

8. I will adhere to the stipulations of the SJRC Tobacco Free Policy.

AGREEMENT	
I,_____, have read, understand and agree to fulfill my responsibilities per the "Contract for Services" outlined above. I further understand my participation in this program is voluntary and I may, at any time, discontinue services. I am here to look at my relationship with alcohol and drugs. That relationship may have caused problems in any of the following areas: legal, family, financial, personal, or a combination of these. I agree to work toward identifying how much of a problem there is and, if recommended, to correct it. In this process I have certain rights and responsibilities. My signing this says I will make an honest effort to keep my agreements. I understand that failure to do so or failure to meet with my counselor within thirty (30) days, may be reason for termination of services and/or referral to another level of care.	
Date:	Client's Signature:
CONSENT FOR CLIENTS UNDER THE AGE OF 18 I, the undersigned, hereby consent to the treatment of the above identified client at the above named facility. I understand that he/she has the right to discharge himself/herself from the above named facility at anytime. I further understand that he/she may be discharged by the facility based on the clinical judgment of the staff.	
Date:	Parent/Guardian Signature:

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS OUTPATIENT SERVICES

GENERAL RELEASE

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS _____and

_____
(AGENCY NAME, FULL ADDRESS & PHONE NUMBER)

_____(or his/her successors)
(Name & Title of a Contact Person, if applicable)

The extent of information to be disclosed Identifying data; pre-admission screening information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care

The purpose of the disclosure authorized herein is to: Coordinate admission, treatment and continuing care efforts.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically six (6) months following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed or re-disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

The Spirit of Recovery
ST Joseph's
ADDICTION TREATMENT & RECOVERY CENTERS

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS OUTPATIENT SERVICES

PARENT/GUARDIAN EMERGENCY CONTACT

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ____ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS_____and

1.: _____ and/or
(NAME OF PARENT/GUARDIAN, RELATIONSHIP, FULL ADDRESS & PHONE NUMBERS, day & evening)

2.: _____
(NAME OF PARENT/GUARDIAN, RELATIONSHIP, FULL ADDRESS & PHONE NUMBERS, day & evening)

The **extent** of information to be disclosed is: Identifying data; pre-admission screening information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care; School Records including medical and immunization records, psychological testing, attendance records and learning problems.

The purpose of the disclosure authorized herein is to: Coordinate admission, treatment and continuing care efforts.

The **purpose** of and need for the disclosure is: Notification in case of an Emergency

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one (1) year following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS OUTPATIENT SERVICES

MEDICAL RELEASE

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS _____and

_____
(AGENCY NAME, FULL ADDRESS & PHONE NUMBER)

_____(or his/her successors)
(Name & Title of a Contact Person, if applicable)

The extent of information to be disclosed __Identifying data; pre-admission screening information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care

The purpose of the disclosure authorized herein is to: Assure Continuity of Medical Care and Follow Up.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically six (6) months following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

ST. JOSEPH'S FAMILY PROGRAM
GENERAL RELEASE

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS and

ST. JOSEPH'S FAMILY PROGRAM
(AGENCY NAME, FULL ADDRESS & PHONE NUMBER)

The extent of information to be disclosed Identifying data; pre-admission screening information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care

The purpose of the disclosure authorized herein is to: Coordinate admission, treatment and continuing care efforts.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one (1) year following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS OUTPATIENT SERVICES

MANDATED LEGAL RELEASE

CS#	
DOB	

Use this form **ONLY** if child is ordered by a court/ probation to receive Alcohol and Drug Abuse counseling services.

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS _____ and

1. _____

_____

2. _____

_____

3. _____

_____
Court, Probation Department, Parole Division, District Attorney, Other Legal Agency:

The extent of information to be disclosed Identifying data; pre-admission screening information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care

The purpose of the disclosure authorized herein is to: Inform the criminal justice agency(ies) listed above of my attendance and progress in treatment regardless of my treatment outcome.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

NON-MANDATED LEGAL RELEASE

Use this form **ONLY** if child is **NOT** ordered by a court/probation to receive Alcohol and Drug Abuse counseling services.

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS and

1. _____

_____

2. _____

_____

3. _____

_____
Court, Probation Department, Parole Division, District Attorney, Other Legal Agency:

The extent of information to be disclosed Identifying data; pre-admission screening information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care

The purpose of the disclosure authorized herein is to: Inform the criminal justice agency(ies) listed above of my attendance and progress in treatment.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically six (6) months following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS OUTPATIENT SERVICES

CS#	
DOB	

LAB RELEASE

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS and

LabCorp, 400 Patroon Creek Boulevard, Albany, NY 12206

The extent of information to be disclosed Identifying Data, Billing Information to include Insurance and/or Medical ID numbers; Name of Insurance Company; any/all information necessary to bill for testing service provided. Diagnosis and Completed Drug Detection Form.

The purpose of the disclosure or re-disclosure authorized herein is to: Laboratory Services / Toxicology Testing.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically six (6) months following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed or re-disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS OUTPATIENT SERVICES

MOUNTAIN LAKE
GENERAL RELEASE

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS and

MOUNTAIN LAKE CHILDREN'S RESIDENCE 386 River Road, Lake Placid, NY 12946
(AGENCY NAME, FULL ADDRESS & PHONE NUMBER)

_____(or his/her successors)
(Name & Title of a Contact Person, if applicable)

The extent of information to be disclosed Identifying data; pre-admission screening information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care

The purpose of the disclosure authorized herein is to: Coordinate admission, treatment and continuing care efforts.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically six (6) months following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

OFFICE OF CHILDREN AND FAMILY SERVICES (OCFS)
MOUNTAIN LAKE
GENERAL RELEASE

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS and

Office of Children and Family Services (OCFS) (518) 486-7078 fax: (518) 486-7625
(AGENCY NAME, FULL ADDRESS & PHONE NUMBER)

Albany Regional Office, 52 Washington Street, Room 262 West, Rensselaer, NY 12144-2796 (or his/her successors)
(Name & Title of a Contact Person, if applicable)

The extent of information to be disclosed Identifying data; pre-admission screening information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care

The purpose of the disclosure authorized herein is to: Coordinate admission, treatment and continuing care efforts.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically six (6) months following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

The Spirit of Recovery
ST Joseph's
ADDICTION TREATMENT & RECOVERY CENTERS

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS OUTPATIENT SERVICES

FINANCIAL SOCIAL SERVICES RELEASE

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS _____ and

Department of Social Services _____ any other 3rd party payer
(AGENCY NAME, FULL ADDRESS & PHONE NUMBER)

they may have me listed as being covered by.

_____(or his/her successors)
(Name & Title of a Contact Person, if applicable)

The extent of information to be disclosed Identifying data; pre-admission screening information; financial and billing information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care

The purpose of the disclosure authorized herein is to: Verify Funding for Services/Treatment and Bill for Services/ Treatment Rendered

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically three (3) years following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS OUTPATIENT SERVICES

FINANCIAL MEDICAID RELEASE

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS _____ and

NYS Department of Health / Office of Medicaid Management _____ and/or any other 3rd party payer they
(AGENCY NAME, FULL ADDRESS & PHONE NUMBER)

may have me listed as being covered by.

The extent of information to be disclosed Identifying data; pre-admission screening information; financial and billing information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care

The purpose of the disclosure authorized herein is to: Verify Funding for Services/Treatment and Bill for Services/ Treatment Rendered

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically three (3) years following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS OUTPATIENT SERVICES

FINANCIAL: INSURANCE, FAMILY, SELF PAY RELEASE

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS_____and

_____and/or
(AGENCY NAME, FULL ADDRESS & PHONE NUMBER)

any other 3rd party payer they may have me listed as being covered by.

The extent of information to be disclosed Identifying data; pre-admission screening information; medical history, physical, laboratory and radiology results; financial and billing information; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care

The purpose of the disclosure authorized herein is to: Verify Funding for Services/Treatment and Bill for Services/ Treatment Rendered

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically three (3) years following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

The Spirit of Recovery
ST Joseph's
ADDICTION TREATMENT & RECOVERY CENTERS

ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS OUTPATIENT SERVICES

SCHOOL GENERAL RELEASE

CS#	
DOB	

I, _____, hereby authorize and consent to communication
(Full Name of Client)

BETWEEN ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS _____ and

_____
(SCHOOL NAME, FULL ADDRESS & PHONE NUMBER)

_____(or his/her successors)
(Name & Title of a Contact Person, if applicable)

The extent of information to be disclosed Identifying data; pre-admission screening information; medical history, physical, laboratory and radiology results; biopsychosocial evaluation; psychiatric evaluation, consultations and notes; diagnosis; treatment; progress; discharge and continuing care; School Records including medical and immunization records, psychological testing, attendance records and learning problems.

The purpose of the disclosure authorized herein is to: Coordinate admission, treatment and continuing care efforts.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically six (6) months following the conclusion of services at ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS. I understand that I have a right to inspect and to obtain a copy of any information disclosed or re-disclosed pursuant to this authorization. I understand that generally ST. JOSEPH'S ADDICTION TREATMENT & RECOVERY CENTERS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____
Signature of Client Date

_____
Signature of Parent, Guardian (if applicable) Date

04/2016

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

Revoked On:_____ Staff Initials:_____

Patient's Last Name	First	M.I.
Case Number		
Facility	Unit	

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED

All information necessary to investigate any alleged incident(s) of abuse or neglect, or other significant incidents, in which I may be named or am otherwise relevant.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION.

1) I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) including its Bureau of Special Hearings, and the NYS Justice Center for the Protection of People with Special Needs (JC) including its Vulnerable Persons Central Register (VPCR) for the purpose of investigating or making determinations regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

2) If I am a minor (under 18), I additionally consent to this program, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) and the Justice Center for the Protection of Vulnerable Persons (JC) providing notification to my parent or legal guardian regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose and obtain such information as herein specified. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

Time period, event or condition extending period specified above: Completion of an investigation by the Justice Center into an allegation of abuse or neglect, or other significant incident, pursuant to Chapter 501 of the Laws of 2012 and determination of a proceeding under NY Social Services Law Article 6, title 6.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Signature of Patient)	(Signature of Parent/Guardian)
(Print Name of Patient)	(Print Name of Parent/Guardian)
(Date)	(Date)